THE BROOKS ACCIDENT & INJURY CLINIC

WELCOME TO THE BROOKS ACCIDENT & INJURY CLINIC

Enclosed are your patient registration forms which include a complete medical history form. Please complete these forms to the best of your knowledge and bring them with you on the day of your appointment. This will help us assess you in a timely manner.

Your appointment date is: _____ at _____

If you are unable to keep your appointment for any reason, please provide 48 business hours in advance notice to avoid rescheduling or a no-show charge.

Please bring the following items with you to your appointment:

- Valid Photo ID
- Insurance Cards
- The enclosed forms filled out.
- Previous medical records and MRI reports associated with your pain condition.

On your initial consultation we will perform a complete evaluation and assess your current medical condition.

Thank you for choosing The Brooks Accident & Injury Clinic.

820 NW 13th Street
Oklahoma City, OK 73106
Phone: (405)943-0303
Fax: (405)272-0515

THE BROOKS ACCIDENT & INJURY CLINIC

NEW PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: Male ☐ Female ☐

Date of Birth: _____ Social Security Number: _____

Driver's License # _____ DL State: _____

Email (appointment Reminders): _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____

Emergency Contact:

Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

What are you being seen for today:

Motor Vehicle Accident: ☐ Personal Injury: ☐ Worker's Comp: ☐

General Information:

Patient's name: _____ Today's date: _____

Date of injury:_____ Marital status: M ☐ S ☐ W ☐ D ☐

☐ Employed ☐ Unemployed ☐ Unemployed Due to accident?

Employment at time of accident: _____

Type of work: ☐ Office/Clerical ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

History of Injury

On the job? ☐ Yes ☐ No

Position in vehicle: ☐ Driver ☐ Passenger:

Did Airbag Deploy: ☐ Yes ☐ No Which Airbag: _____

Lose Consciousness? ☐ Yes ☐ No Approx. how long did you lose consciousness? _____

Disoriented After Accident? ☐ Yes ☐ No Approx. how long were you disoriented? _____

After crash

Did you go to hospital ☐ Yes ☐ No

If you went to hospital, when? ☐ At time of accident ☐ Next day ☐ Other: _____

Name of Hospital:_____

If you didn't go to the hospital after the accident, then where did you go? _____

PATIENT'S NAME: _____ DOB: _____

THE BROOKS ACCIDENT & INJURY CLINIC

Allergies:

Drug Allergies? ☐Yes ☐No

List all allergies & reactions:

_____

_____

Food Allergies? ☐ Yes ☐ No

List all allergies & reactions:

_____

_____

Environmental Allergies? ☐ Latex ☐ Tape ☐ Iodine ☐ Other _____

Current Medications:

Please check any blood thinners you are taking:

☐ Aspirin	☐ Anti-inflammatory	☐ Lovenox	☐ Coumadin
☐ Warfarin	☐ Pletal	☐ Aggrenox	☐ Pradaxa
☐ Ticlid	☐ Plavix	☐ Heparin	

Prescribing Physician_____

Please list all medications you are taking:

Medication	Dose	Frequency	Prescribing Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT'S NAME: _____ DOB: _____

THE BROOKS ACCIDENT & INJURY CLINIC

Smoking History:

Smoking Status: ☐ Never ☐ Occasional ☐ Daily How many packs per week? _____

Past Surgical History: (Major Events)

Please check box for any surgical procedures you have had and the date.

Abdominal Surgery:

☐ Gallbladder _____

☐ Appendix _____

☐ Hernia _____

☐ Laparotomy _____

☐ Other _____

Spine & Back Surgery:

☐ Fusion _____

☐ Laminectomy _____

☐ Discectomy _____

☐ Other _____

Gynecologic Surgery:

☐ Hysterectomy _____

☐ Tubal Ligation _____

☐ C-Section _____

☐ Other _____

Joint Surgery:

☐ Foot _____

☐ Knee _____

☐ Hip _____

☐ Elbow _____

☐ Shoulder _____

☐ Other _____

Cardiac Surgery:

☐ CABG _____

☐ Valve Repair _____

☐ Stent Placement _____

☐ Aneurysm _____

☐ Vascular _____

☐ Other _____

☐ I have never had any surgical procedures.

Please list any other surgical procedures performed:

_____

_____

PATIENT'S NAME: _____ DOB: _____

FAMILY HISTORY

If you or a family member has or has had any of the following problems, circle the appropriate letter for the family member: S=Self M=Mother F=Father

Anemia / Blood Disorders	S	M	F
Arthritis	S	M	F
Asthma / Lung Problems	S	M	F
Cancer	S	M	F
Diabetes	S	M	F
Drug / Alcohol Abuse	S	M	F
Epilepsy / Seizures	S	M	F
Eye or Vision Problems	S	M	F
Heart Attack	S	M	F
Heart Disease	S	M	F
Hepatitis	S	M	F
High Blood Pressure	S	M	F
HIV Infection	S	M	F
Kidney Disease	S	M	F
Liver Disease	S	M	F
Mental Illness	S	M	F
Pancreatitis	S	M	F
Stroke	S	M	F
Thyroid / Endocrine Problems	S	M	F

☐ I have no significant family medical history.

☐ I am adopted.

PATIENT'S NAME: _____ DOB: _____

Please tell us about your injuries from the accident: List one injury per complaint. If you have any questions, please ask the front desk. It is very important for you to tell us about each injury.

Complaint # 1:_____ Rate Your Pain: (1-10) _____

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Pain Description: (Check all that apply)

☐ Spasms / Cramping ☐ Dull / Achy ☐ Shooting

☐ Numbness / Tingling ☐ Sharp / Stabbing

Frequency of your Pain:

☐ Constant ☐ Intermittent (comes and goes)

Does your pain radiate? If yes it radiates to: _____

Complaint # 2:_____ **Rate Your Pain: (1-10) _____**

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Pain Description: (Check all that apply)

☐ Spasms / Cramping ☐ Dull / Achy ☐ Shooting

☐ Numbness / Tingling ☐ Sharp / Stabbing

Frequency of your Pain:

☐ Constant ☐ Intermittent (comes and goes)

Does your pain radiate? If yes it radiates to: _____

PATIENT'S NAME: _____ DOB: _____

Complaint # 3:_____ **Rate Your Pain: (1-10) _____**

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Pain Description: (Check all that apply)

☐ Spasms / Cramping ☐ Dull / Achy ☐ Shooting

☐ Numbness / Tingling ☐ Sharp / Stabbing

Frequency of your Pain:

☐ Constant ☐ Intermittent (comes and goes)

Does your pain radiate? If yes it radiates to: _____

Complaint # 4:_____ **Rate Your Pain: (1-10) _____**

What makes your pain BETTER? _____

What makes your pain WORSE? _____

Pain Description: (Check all that apply)

☐ Spasms / Cramping ☐ Dull / Achy ☐ Shooting

☐ Numbness / Tingling ☐ Sharp / Stabbing

Frequency of your Pain:

☐ Constant ☐ Intermittent (comes and goes)

Does your pain radiate? If yes it radiates to: _____

PATIENT'S NAME: _____ DOB: _____

PATIENT MEDICAL HISTORY: (ONGOING MEDICAL PROBLEMS)

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Other

Eyes:
- ☐ Blurred Vision
- ☐ Photophobia (Light Sensitive)
- ☐ Visual Changes
- ☐ Other

Ears / Nose / Throat:
- ☐ Hearing Changes
- ☐ Bleeding Gums
- ☐ Dental Problems
- ☐ Other

Cardiac:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Fast Heart Rate
- ☐ Slow Heart Rate
- ☐ Edema (Swelling)
- ☐ Other

Neurological:
- ☐ Numbness / Tingling
- ☐ Seizures
- ☐ Memory Impairment
- ☐ Weakness

Neurological Con't:
- ☐ Incontinence
- ☐ Loss of Balance
- ☐ Loss of Coordination
- ☐ Other

Mental Health:
- ☐ Depression
- ☐ Anxiety
- ☐ Suicidal Thoughts
- ☐ Sleep Difficulty
- ☐ Restlessness
- ☐ Crying
- ☐ Agitation
- ☐ Insomnia
- ☐ Other

Pulmonary:
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Other

Hematologic:
- ☐ Taking Blood Thinners
- ☐ Easy Bruising
- ☐ Excessive Bleeding
- ☐ Swollen Glands
- ☐ Other

Musculoskeletal
- ☐ Neck Pain
- ☐ Low Back Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Morning Stiffness
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Difficulty Walking
- ☐ Other

Integument:
- ☐ Rash
- ☐ Hives
- ☐ Other

Endocrine:
- ☐ Hair Loss
- ☐ Excessive Thirst
- ☐ Other

Gastrointestinal:
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea / Vomiting
- ☐ Abdominal Pain
- ☐ Jaundice
- ☐ Reflux
- ☐ Other

PATIENT'S NAME: _____ DOB: _____

I certify that the above information is accurate, complete and true. I authorize The Brooks Clinic Providers, Physicians, associates, assistants, and other health care providers it may deem necessary to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give consent for The Brooks Clinic Providers and physicians to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review The Brooks Clinic notice of privacy practices, which is displayed for public inspection at its facility. This notice describes how my protected health information may be used and disclosed, and how I may access my health records. I authorize The Brooks Clinic to release my protected health information (medical records) in accordance with its notice of privacy practices. This includes, but not limited to my referring physician, primary care physician, and any physician(s) you may be referred to. I also authorize The Brooks Clinic to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that The Brooks Clinic will not release my protected health information to any other party (including family) without completing a written patient authorization for use and disclosure of protected health information form available at the facility or in the new patient packet.

Signature _____ Date_____

RELEASE OF INFORMATION

If a patient wishes another individual to receive medical information such as test results, etc., or if the patient is unable to receive those results, that patient may choose to designate a person who is authorized to receive that information.

I hereby authorize the release of my medical information to the following designed persons: (Check one or all)

☐Spouse Name _____

☐Child/Children's Name _____

☐Other _____

My signature indicates that I have read the above and grant the request. I understand that if I do not sign, or list any person, the information will not be given to anyone but the patient. I also understand that I can revoke this authorization at any time. The request must be in writing to The Brooks Accident & Injury Clinic.

Patient Name _____ Date _____

Patient Signature _____

THE BROOKS ACCIDENT & INJURY CLINIC

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices which describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information:

Printed Name of Patient _____

Signature of Patient _____Date _____

OR

Printed Name of Personal Representative_____

Signature of PR_____ Date_____

Description of Authority of Personal Representative _____

For office use only

The Brooks Clinic staff will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient (or personal representative) is unwilling and or unable to sign this acknowledgement, the clinic must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

If Acknowledgement is not signed the clinic's on-site Practice Administrator/Office Manager must complete the following:

Does patient have a copy of the Privacy Notice? Yes No

Please explain why the patient was unable to sign an acknowledgement form and your efforts in trying to obtain the patient's signature: _____

THE BROOKS ACCIDENT & INJURY CLINIC

ASSIGNMENT OF BENEFITS

NAME OF PATIENT: _____

DATE OF ACCIDNET/INJURY: _____

Release of information, assignment of benefits and out-of-network contract:

I authorize, The Brooks Accident & Injury Clinic, and its employed physicians to release any necessary information regarding any illness/injury to my insurance company and/or attorney in regards to the above accident.

I authorize the responsible insurance company and/or attorney to pay directly to The Brooks Accident & Injury Clinic all medical benefits pertaining to services rendered by this clinic, if any, otherwise payable to me.

If the responsible insurance policy prohibits direct payment to my physician, then I hereby instruct and direct my insurance carrier to make out any benefit check payable to me and mail as follows

THE BROOKS ACCIDENT AND INJURY CLINIC
820 Northwest 13th
Oklahoma City, OK 73106

I understand that charges which are not payable by the insurance are my responsibility. I understand that my credit report may be obtained to assist The Brooks Accident & Injury Clinic in any collection efforts.

I understand that if I have health insurance in force during my treatment for this accident, I am contracting outside of my network for any treatment received relating to this accident. Any network discounts or write-off's will not apply for any treatment related to this accident. I understand that The Brooks Accident & Injury Clinic will not file to my health insurance for services rendered relating to this accident, UNLESS it becomes the only source of payment; at which time it will be out of network and I am still ultimately responsible for any balance not paid by any other source.

A copy of the above is considered as valid as the original copy.

Patient Signature: _____ Date: _____

Custodial Parent or Legal Guardian must sign if Patient is a minor under the age of 18 or legally incapacitated.

Witness Signature: _____ Date: _____

THE BROOKS ACCIDENT & INJURY CLINIC

ASSIGNMENT, AUTHORIZATION AND LIEN

I, hereby authorize and direct my insurance company and /or my attorney, to pay directly to The Brooks Accident & Injury Clinic such sums as may be due and owing this office an assignee for services rendered the undersigned, by reason, of accident or illness, and by reasons of any other bills that are due or may become due, and to withhold such sums from any disability benefits, including, but not limited to foundation grants, governmental or agency benefits, medical payments benefits. No fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse the undersigned or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed to this office and assignee.

The parties further agree that, in the event my insurance company obligated to make payments to me upon charges made by this office and assignee for its services refuses to make such payments, this agreement is to act as an assignment of the undersigned rights and benefits to the extent of the office's services provided; therefore, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name and further I authorize this office and assignee to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds of any settlement, judgment or verdict which may be paid to the undersigned as a result of the injuries or illness for which I have been treated by said office and assignee. The undersigned patient and assignee further agree that the assignee's right for payment from the undersigned patient shall be tolled by any statute of limitation until a reasonable time has lapsed after either negotiations or litigation between third parties and the undersigned patient are resolved.

Initials:_____

It is further agreed that the undersigned patient shall remain personally responsible for the total amounts due to this office and assignee for its services. This office an assignee for and in consideration of their rights for immediate payment on the

indebtedness owed at this time and which may become due in the future agrees to forego collections of the aforementioned monies owed for a reasonable length of time. This assignee, however, reserves the right to revoke this agreement upon thirty (30) days written notice to the undersigned patient this assignee demands payment after said notice has expired.

I authorize this office to release any information pertinent to my case to any insurance company, adjustor, or attorney to facilitate collection under this assignment, lien, and authorization. I agree that the above mentioned office by given power of attorney to endorse and/or sing my name on any and all checks for payment of any indebtedness owed this office and assignee.

I do attest that I have come to this clinic for purposes of acquiring medical care. I am here for my medical problems and have no intent to mislead or defraud my treating practitioners in any way that might result in inappropriate charges to third party payers, federal, state, or local government, or insurance carriers. Further I attest that my injuries are real and that I am in pain and in need of medical treatment as a result of the medical condition for which I am consulting The Brooks Accident & Injury Clinic. I also attest that I understand the context of this statement with complete comprehension of its content.

Print Patient's Name: _____

_____ _____

Patient's Signature Date

THE BROOKS ACCIDENT & INJURY CLINIC

HOW DID YOU HEAR ABOUT US?

- ☐ DOCTOR'S OFFICE, CLINIC or ER WAITING ROOM
  - o NAME _____
- ☐ TV
  - o FOX 25 o CW 34 o KAUT 43 o CABLE o OTHER _____
- ☐ INTERNET SEARCH
- ☐ FACEBOOK
- ☐ FRIEND/RELATIVE
- ☐ BILLBOARD
- ☐ ATTORNEY _____
- ☐ I AM A FORMER PATIENT
- ☐ PHONEBOOK
- ☐ THE SIGN IN FRONT OF THE CLINIC
- ☐ RADIO
- ☐ OTHER _____